STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355101	A. BUILDING _____ B. WING _____	01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAKOTA ALPHA	1303 27TH STREET NW MANDAN, ND 58554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 01/25/21 and concluded on 01/27/21.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		1/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/17/2021

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy/procedure review, and staff interview, the facility failed to ensure the medical record and resident Care Card accurately reflected the resident's code status for 1 of 14 (Resident #7) sampled residents. Failure to ensure the resident's medical record and Care Card reflected his/her wishes prevents staff from following the resident's choices in the event of a medical emergency. Findings include: Review of the policy, "Advanced Directives Policy and Procedure," dated 12/31/18, stated, "An Advance Directive is a written statement of a person's wishes regarding medical treatment, . . . made to ensure those wishes are carried out should the person be unable to communicate them in a catastrophic event. . . . Dakota alpha will follow the written directions of the Resident or legally assigned agent . . . " Review of Resident #7's medical record occurred on all days of survey and identified "Code Status: DNR [do not resuscitate] . . ." Physician's orders, dated 08/01/18, identified "DNR." A document in the medical record titled "Emergency Care	F 578	1. The Director of Nursing, Assistant Director of Nursing, Administrator, MDS and Social Worker reviewed the Advanced Directive policy, which included reviewing and updating the code status in the computer in a timely manner. 2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: Audits were performed by the Social Worker and MDS on Advance Directives throughout the facility to ensure that the signed orders in the medical records and resident care cards (Kardex) matched the orders that were in the computer for all residents. 4. The Director of Nursing, Social Worker or Assistant Director of Nursing will review code status with admission and readmission, and annually. Social Services or designee will audit Advance Directive orders with 5 random residents weekly for 4 weeks, then 5 residents monthly x 4 months, and then ongoing as needed. Audits will be submitted to the Director of Nursing or designee for review. Results will be reviewed in QAPI	

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F 578	Continued From page 2 Statement," dated 05/01/20, stated, ". . . I request the following be done for me in the event of a cardiac arrest: . . .CODE STATUS: LEVEL I - Total Support Provide chest compressions, artificial respiration, and defibrillation. Transfer to the hospital." During an interview on 01/26/21 at 2:11 p.m., a staff nurse (#9) stated she refers to the top page/dashboard of the medical record to determine a resident's code status. The staff nurse (#9) stated the code status is also on the Care Card, which is located in each resident's room on the back of the mirror cabinet. Observation of the Care Card located in Resident #7's room showed a red sticker with "DNR" for the code status. During an interview on 01/26/21 at 5:30 p.m., an administrative nurse (#1) confirmed staff had not changed the Code Status in the medical record or on the Care Card when Resident #7 signed the Emergency Care Statement on 05/01/20.	F 578	quarterly meeting for 6 months and finding no trends, will be reviewed again on an as needed basis. 5. Correct action completion date: 1/28/2021	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		2/2/21

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F 583	Continued From page 3 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, resident and staff interview the facility failed to ensure personal privacy for 1 of 2 sampled residents (Resident #9) who expressed concerns regarding personal privacy. Failure to ensure privacy when using the bathroom/shower is an infringement on residents' rights and may lead to loss of dignity and safety. Findings include: Review of the facility policy titled "Promoting/Maintaining Resident Dignity" dated May 2020, stated, "Policy: It is the practice of this	F 583	1. The Administrator entered the policy into the Relias training program, promoting/maintaining resident dignity policy for all staff to review and sign that they have read and attest by 2/28/21. Any staff who have not completed the training will be educated on a 1 to 1 basis with the administrator or designee by 3/2/21. 2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: On 1/28/21 new locking mechanism was ordered to prevent male resident from entering female resident #9	

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F 583	Continued From page 4 facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. . . Maintain resident privacy." - During an interview on 01/27/21 at 9:55 a.m., Resident #9 expressed concerns regarding her privacy. She stated the bathroom she shares with a male resident does not have a lock and he could enter her room anytime. Observation of the bathroom doors between the resident rooms and the shared bathroom showed the doors locked in such a way the male resident could still enter Resident #9's room or the shared bathroom anytime. During an interview on 01/27/21 at 10:30 a.m., an administrative staff member (#7) stated Resident #9 had moved closer to the nurse's station due to behaviors. After an observation of Resident #9's room and bathroom, administrative staff members (#7 and #8) confirmed the male resident could enter the shared bathroom and Resident #9's room at any time due to the lack of a door locking mechanism.	F 583	private room through the shared bathroom. On 1/28/21, male resident agreed to change rooms with a female resident who also agreed on the room change. This room change happened on 2/2/21. New locking mechanism installed on resident #9 door to provide privacy. 4. The Director of Nursing, Assistant Director of Nursing, Administrator, Social Worker, or designee will conduct random room observations of all resident private bedrooms and shared bathrooms to ensure personal privacy is being followed regarding the locking mechanism. 5 random residents weekly for 4 weeks, then 5 random residents monthly x 4 months, and then ongoing as needed. Audits will be submitted to the Administrator or designee for review. Results will be reviewed in QAPI quarterly meeting for 6 months and finding no trends, will be reviewed again on an as needed basis. 5. Correct action completion date: 02/02/2021	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		2/17/21

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F 684	Continued From page 5 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, professional reference, facility policy review, record review, and staff interview the facility failed to ensure proper positioning for 2 of 2 sampled residents (Residents #3 and #5) observed eating/drinking in an unsafe position. Failure to ensure staff provided proper positioning when giving fluids/enteral feeding/medication, placed Residents (#3 and #5) at risk for aspiration. Findings include: Swigert's "The Source for Dysphagia," 3rd ed., Pro-Ed, Inc., Texas, 2007, page 125 and educational handouts, identified, ". . . During the oral intake of . . . food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. . . ." Review of the facility policy titled "Peg Tubes" occurred on 01/26/21. The undated policy stated, ". . . The resident should be in at least a 45 degree angle. Residents should remain upright for 30 minutes after the feeding either by having the head of the bed elevated at least 30 degrees or by sitting upright in a chair. . ." - Observation on 01/26/21 at 12:35 p.m., showed Resident (#3) received medication and food bolus via G-tube from staff nurse (#9) as ordered. During medication pass the resident was	F 684	Proper Positioning 1. The Director of Nursing, Assistant Director of Nursing and Speech Therapist reviewed the policy and procedure for proper positioning for residents while eating, drinking, enteral feeding and medication on 2/17/21. The Administrator entered the updated policy procedure into the Relias training program, proper positioning for residents while eating, drinking, enteral feeding and medication for all staff to review and sign that they have read and attest by 2/28/21. Any staff who have not completed the training will be educated on a 1 to 1 basis with the Director of Nursing, Assistant Director of Nursing and Speech Therapist or designee by 3/2/21. 2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: Director of Nursing, Assistant Director of Nursing and MDS Coordinator reviewed and updated the policy on proper positioning for residents while eating, drinking, enteral feeding and medication on 2/3/21. 4. The Director of Nursing or designee will conduct random observations of staff positioning residents while eating, drinking, enteral feeding and medication. The random observations weekly for 4 weeks, then random monthly x 4 months, and then ongoing as needed. Observations will be submitted to the	

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F 684	Continued From page 6 positioned lying flat. Resident was advised to lie down for a while, after the medication pass, with no elevation of his head. During an interview on 01/27/21 at 4:00 p.m. an administrative nurse (#1) verified that she would expect her staff to follow the facility policy for tube feeding, have the head of the bed at correct level, and have the resident lie at 30 degrees or sit in a upright position as ordered. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia, history of subarachnoid hemorrhage, and left-sided spastic hemiplegia. A speech therapy evaluation, dated 12/11/20, identified, ". . . Currently [Resident #5] does not have his partials due to him taking them out and breaking them. However even without his teeth he is able to eat a mechanical soft texture. He has his food cut up and drinks thin liquids with a straw. . . ." The current care plan identified, ". . . Supervision while eating, provide cues . . . Assist of 1 as needed. . . ." Observations showed the following: * 01/25/21 at 1:25 p.m., two certified nursing assistants (CNAs) (#2 and #3) transferred Resident #5 into bed with a full body lift and provide toileting cares. After raising the head of the bed to an approximate 30 degree angle, the CNA (#3) gave Resident #5 a drink of water. * 01/26/21 at 1:44 p.m., two CNAs (#3 and #4) transferred Resident #5 into the bed with a full body lift and provided toileting cares. A certified	F 684	Speech Therapist or designee for review. Results will be reviewed in QAPI quarterly meeting for 6 months and finding no trends, will be reviewed again on an as needed basis. 5. Correct action completion date: 2/17/21 Continuous Glucose Monitoring System 1. Director of Nursing, Assistant Director Nursing and MDS reviewed manufacture user guides and created policy and procedures for the use of the continuous glucose monitoring system and updated orders. 2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: Director of Nursing completed a continuous glucose monitoring assessment with resident #19 to determine competency. Orders updated for nursing to verify resident #19 changed transmitter and sensor on days specified by continuous glucose monitoring system manufacture guidelines. The Administrator entered the policy and procedures into the relias training program, Continuous Glucose Monitoring System for nursing staff to review and sign that they have read and attest by 2/28/21. Any nursing staff who have not completed the training will be educated on a 1 to 1 basis with the Director of Nursing, Assistant Director of Nursing or designee by 3/2/21. 4 . The Director of Nursing or designee will conduct observations and or audits of nursing staff following manufacture guidelines and policy and procedures for	

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F 684	Continued From page 7 medication assistant (CMA) (#5) then raised the head of Resident #5's bed to an approximate 45 degree angle and administered his medications with pudding while Resident #5 laid on the bed leaning heavily towards his right side with his head resting on the edge of the mattress. During an interview on 01/27/21 at 3:10 p.m., when asked questions pertaining to positioning, a speech therapy staff member (#6) stated, "It is normal for him to lean to the side like that. He should be up higher. I'd be worried." 2. Based on record review, review of a continuous glucose monitoring (CGM) system instruction pamphlet, and resident and staff interview, the facility failed to provide necessary treatment and care for 1 of 1 resident (Resident #19) who used a CGM system. Failure to ensure the facility had a physician order and documentation regarding changing of the CGM system sensor placed the resident at risk for high or low blood sugar and related complications. Findings include: The CGM system instruction pamphlet stated, ". . . insert sensor . . . attach transmitter . . . after 10 days sensor session ends . . ." Upon request the facility failed to provide a policy regarding the use of the CGM system. During an interview on 1/25/21 at 10:22 a.m. Resident #19 stated he uses a CGM sensor to check his blood sugars and he changes the sensor every 14 days.	F 684	continues glucose monitoring system. The observations and or audits will be every 10 days for 1 month, then monthly x 4 months, and then ongoing as needed. Observations will be submitted to the Assistant Director of Nursing or designee for review. Results will be reviewed in QAPI quarterly meeting for 6 months and finding no trends, will be reviewed again on an as needed basis. 5. Correct action completion date: 2/19/21	

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F 684	Continued From page 8 Review of Resident #9's medical record occurred on all days of survey. Diagnoses included Type 1 Diabetes Mellitus. The physician's orders stated, "[CGM system] for glucose check right arm 3 times a day." The current care plan stated ". . . has uncontrolled Type 1 Diabetes Mellitus. He has a [CGM] device . . . Educate resident/family/caregivers as to the correct protocol for glucose monitoring and insulin injections. Monitor blood sugars as ordered and compare with CGM. . . ." During an interview on 1/26/21 at 3:45 p.m., an administrative nurse (#1) stated staff are not documenting when Resident #19 changes his sensor as he does this himself. This nurse did not know how often the sensor is changed and directed me to a staff nurse (#9). The staff nurse (#9) did not know how often the Resident #19 changed his CGM sensor and stated "ask the resident." The facility failed to develop a policy for the use of a CGM system device, to ensure physician's orders and documentation included how often to change the sensor, and lacked education on the use of a CGM system device.	F 684		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility	F 727		2/8/21

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F 727	Continued From page 9 must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility's nursing staff schedule and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for three days of the 42-day period from 12/13/20 to 01/23/21. Failure to ensure sufficient, qualified nursing staff are available daily has the potential to affect all the residents residing in the facility. Findings Include: The facility provided a copy of the nurse's schedule for the time period of 12/13/20 to 01/23/21. A review of the schedules showed the facility lacked the required RN coverage on 12/13/20, 12/27/20, and 01/23/21. During an interview on 01/27/21 at 8:53 a.m., an administrative nurse (#1) confirmed the facility lacked eight consecutive hours of RN coverage on 12/13/20, 12/27/20, and 01/23/21.	F 727	1. Administrator and Director of Nursing reviewed the current nursing scheduled 1/28/21 to determine when 8 hours of RN coverage was needed. 2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: Director of Nursing and Administrator reached out to travel agency to contract an RN for 8 hours during the needed coverage time. Administrator requested to continue to recruit an RN as a permanent staff to cover every other weekend and holidays to cover the 8-hour RN coverage. Travel agency and Dakota Alpha RN staff will cover any hours that do not meet the 8 hours of RN coverage until RN can be hired. 4. The Social Worker, Administrator, Director of Nursing, or designee will conduct audits of nursing schedules to determine the 8 hours of RN coverage. The random observations and or audits will be weekly for 4 weeks, then random monthly x 4 months, and then ongoing as needed. Observations and or audits will be submitted to the Social Worker or designee for review. Results will be reviewed in QAPI quarterly meeting for 6	

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F 727	Continued From page 10	F 727	months and finding no trends, will be reviewed again on an as needed basis. 5. Correct action completion date: 2/8/2021	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to label 1 of 2 multi-dose insulin pens (long-acting) in 1 of 1 medication cart. Failure to label the multi-dose	F 761	1. Director of Nursing and MDS reviewed and updated the Labeling of medications and biologicals. The insulin pen policy and procedure were updated to include	2/28/21

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DAKOTA ALPHA	1303 27TH STREET NW MANDAN, ND 58554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 11 pens with the date opened and the expiration date, increases the risk of residents receiving outdated medication with reduced efficacy. Findings include: Review of facility policy titled "Medications" dated 03/23/19, stated, ". . . Insulin: Insulin bottles/pens must be marked with the date the item was opened and initials of staff who opened the pen/bottle at that time . . . " Observation of the medication cart occurred on 01/27/21 at 12:15 p.m. Facility staff failed to label one long-acting multi-dose insulin pen with an open and expiration date. A staff nurse (#10), present at the time of the observation, agreed staff should label the insulin pen with an open and expiration date.	F 761	insulin 28-day expiration date calculator. 2. The facility has determined that any resident has the potential to be affected. 3. Action Taken: Director of Nursing and MDS updated the nursing and infection control folders on the computer. All nursing has access to company computer and the location of the folders. The Administrator entered the policy and procedures into the Relias training program, Label/Store Drugs and Biologicals and insulin pen policy and procedure nursing staff to review and sign that they have read and attest by 2/28/21. Any nursing staff who have not completed the training will be educated on a 1 to 1 basis with the Director of Nursing, Assistant Director of Nursing, or designee by 3/2/21. 4. The MDS, Administrator, Director of Nursing or designee will conduct observations and or audits of labeling of medications and biologicals and insulin pen procedures. The observations and or audits will be weekly for 4 weeks, then monthly x 4 months, and then ongoing as needed. Observations will be submitted to the Social Worker or designee for review. Results will be reviewed in QAPI quarterly meeting for 6 months and finding no trends, will be reviewed again on an as needed basis. 5. Correct action completion date: 2/28/21	